London Health Sciences Centre

COLONOSCOPY REFERRAL

Division of General Surgery

Email: gensurg.referral@lhsc.on.ca Fax: 519-685-8273 Phone: 519-685-8500 ext. 57420

ALL SECTIONS OF THE FORM MUST BE COMPLETED – PLEASE PRINT CLEARLY or TYPE DIRECTLY INTO FORM

All questions contained in this questionnaire are strictly confidential

Patient Name:			☐ M ☐ F	**Referring Physician:**	
Marital status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			**Address:**	
DOB:	**Health Card #:**		**VC:**	**City:**	**Postal Code:**
Address:		**City**:		**Phone:**	**Fax:**
Postal Code:	**Phone:**	**Alternate:**		**MOH Billing #:**	**Office Email:**

PATIENT HEALTH HISTORY (THIS SECTION MUST BE COMPLETED)

Date of last colonoscopy exam:	**Performed by:**

Reason for Referral (symptoms & family history)

List of patient medications (including over-the-counter drugs, such as vitamins) (attach a separate page if necessary)

Select Preferred Physician (if patient was previously seen by a Gastroenterologist please contact their office & DO NOT use this form)

☐ Next Available Surgeon – any Campus

☐ **Next Available Surgeon – University Hospital**
☐ Dr. N. Alkhamesi
☐ Dr. P. Colquhoun
☐ Dr. W. Davies
☐ Dr. A. Elnahas
☐ Dr. J. Hawel
☐ Dr. C. Schlachta
☐ Dr. J. Van Koughnett

☐ **Next Available Surgeon – Victoria Hospital**
☐ Dr. M. Brackstone
☐ Dr. D. Gray
☐ Dr. S. Latosinsky
☐ Dr. M. Ott
☐ Dr. N. Parry
☐ Dr. T. Zwiep

Note: EMR and other physician's office referrals will be accepted. If you are sending this referral to the central referral office, please **DO NOT** duplicate and send to the physician directly. **Form updated: November 8, 2021**